

REAL PEOPLE



REAL PROBLEMS



REAL SOLUTIONS

THE PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT

MESSAGES FROM ACROSS AMERICA





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THE PREVENTIVE HEALTH AND HEALTH SERVICES GRANT

SELECTED STORIES FROM GRANTEEES

JULY 2006

Clean Water for All: How Block Grant Funds have Enabled Alabama to Address Community Waterborne Disease Prevention

Issue

Images of three low-income families in Lowndes County, Alabama, forced to live in tents after septic tanks failed, were seen on TV screens across the nation in 2003–2004. These images gave Americans a look into a reality faced by many rural Alabamians. Failing septic tanks place about 340,000 low-income persons in rural Alabama who use well water for consumption at risk for waterborne disease. Contaminations of water wells in rural areas is an issue continuously needing to be addressed.

- Approximately 40–50% of the private well water samples routinely tested by the Alabama Department of Public Health were contaminated with fecal coliforms, nitrates, and pesticides.
- Percentages are even higher for privately dug shallow wells less than 30 feet and for water sources in rural and coastal areas.
- There is a significant cost to investigate and manage outbreaks, as well as costs of medical treatment and lost productivity for those that become ill.

Intervention

While the Alabama Department of Environmental Management regulates and funds the protection of large municipal and community drinking water wells and well drillers, it does not have funds for private drinking wells. Consequently, approximately \$109,000 of the state's Preventive Health and Health Services Block Grant (PHHSBG) is used to develop a statewide monitoring system that enables the state to identify problems and take corrective action for both community and private wells. During 2005, the Alabama Department of Public Health environmentalists and soil scientists funded by the PHHSBG Waterborne Disease Prevention Program did the following:

- Investigated and evaluated more than 150 failed septic tanks in sensitive areas statewide.
- Worked with each owner to repair the septic tanks to meet sewage discharge standards.
- Evaluated approximately 50 proposed subdivisions for suitability of septic tanks.
- Provided a detailed soil analysis and consultation to prevent the contamination of sensitive groundwater, natural springs, and nearby water wells.
- Conducted continuing education programs with the Alabama Onsite Wastewater Association and other municipal and academic institutions.
- Trained over 500 septic tank installers, pumpers, manufacturers, engineers, and surveyors in the proper installation of onsite sewage systems.



Impact

Alabama established a goal of no more than two outbreaks of waterborne disease per year. PHHSBG funds have enabled the state to investigate private wells and to review in real time the results of all well water samples (both private and community) analyzed in the state clinical laboratories so that investigation and corrective action could be implemented quickly. As a result—

- There were no waterborne disease outbreaks from 2003 to 2005.
- Approximately 96% of the state's public water systems now meet the federal drinking water standards.
- Lower contamination levels require fewer chemicals to be applied to the water. Based on 780 community water systems, the result is **a saving in chemical costs of at least \$300,000 per year.**
- The cost of an epidemiological investigation of a single outbreak in a typical rural Alabama county costs approximately \$25,000. This cost was eliminated.

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Eat and Play the Native Way: Preventing Diabetes with Navajo Nation Schoolchildren

Issue:

American Indians and Alaska Natives suffer from the world's highest rates of diabetes, a disease that, when left untreated, can lead to loss of limbs, eyesight and other serious health problems. Once limited to adults, diabetes is increasingly affecting American Indian and Alaska Native children and adolescents, something of particular concern in Arizona, home to 255,879 American Indians.

- Diabetes in American Indians/Alaska Native aged 15–19 increased 106% from 1990–2001.
- About 15.1% of American Indians/Alaska Native have diabetes, while diabetes affects 7% of the overall population.
- About 5% of Arizona's population is American Indian, compared to less than 1% of the total U.S. population.
- Diabetes cost the United States \$132 billion in 2002.

Intervention:

This program addresses two of the most important risk factors for diabetes—physical inactivity and poor nutrition. Recognizing the importance of the health issues these risk factors cause and that tradition and culture are highly honored by the Navajo population, *Eat and Play the Native Way* was developed in 2002. Funded by the Preventive Health and Health Services (PHHS) Block Grant, the Coconino County Health Department and the Navajo Nation's Kaibeto Boarding School developed this program using the evidence-based Promoting Lifetime Activity for Youth Program as a foundation. The program elements include the following:

- Teaching six traditional and culture-based lessons for children in grades K-3 to introduce the concepts of physical activity and healthy eating.
- Teaching traditional Native American physical activity games, such as Choom-Choom Game, Hot Rocks and Hoop Toss.
- Educating students on the importance of healthy eating using traditional Native American foods, such as sumac berries, hominy, and pinon nuts.



Impact:

2002—157 students and eight teachers at Kaibeto Boarding School participated in the pilot test of *Eat and Play the Native Way*.

2003/2004—1,072 students and 59 teachers in five Navajo Nation schools participated in the program.

2005—Continued implementation of the program with an evaluation component.

Until the evaluation of the program is complete, its success can be measured by feedback from students and teachers. Feedback from participant educators includes—

"The program has been well received and uniquely meets the physical activity, nutritional education and the cultural needs of our students."

"Before the implementation of the Eat and Play the Native Way program, there was no consistent and comprehensive health education for these grade levels at these schools. The lesson plans give teachers a new resource for introducing nutrition and physical activity concepts."

Future PHHS Block Grant funding of this program will allow for continued program improvement, outreach to more Navajo children and dissemination to the other 20 American Indian Nations in Arizona.

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Arkansas Prevents TB Outbreak in Marshall Islanders Thanks to PHHS Block Grant

Issue:

When Regional Director Don Murray realized that the culturally-guarded communities of Marshall Islanders and their Hispanic coworkers in Northwest Arkansas were on the verge of another Tuberculosis (TB) outbreak, he feared his regional resources were not enough and his public health workers not equipped to contain the disease.

The Marshallese have a Compact of Free Association with the United States allowing them to live and work in the United States with no additional legal documentation or health screening. The population residing in Arkansas is estimated to be 10,000 with many of the Marshallese coming to the state to work in the poultry industry in northwest Arkansas.

Although the Marshallese have lived in Arkansas for over a decade, their culture and language is still unique and apart.

- Due to past experience, the Marshallese have a mistrust of government, in general.
- Their complex language has a limited vocabulary of 30,000 words, making translation into English extremely difficult. Just explaining how to take the TB medicine is a challenge for the public health nurses.
- The Marshallese rarely make individual decisions; they consult with the "elders," or decide as a group. The good of the community is considered over the individual. Because most of the "elders" are still in the islands, their family groups have become the decision makers.

As a public health manager, Don Murray had additional concerns. If he diverted all of his manpower and resources into breaking through these cultural barriers, how would there be time or funds for any other public health work to be done, including the TB treatment?

Intervention:

Since the PHHS grant is Arkansas' major source for TB treatment and skin-testing drugs, grant funding was made available so that the region had the medicine needed to assure that the battle could be won. Working mostly in the Springdale, Arkansas area, the TB Outreach Team consisting of an RN Project Coordinator and two bilingual Outreach Workers, one Hispanic and one Marshallese, did the following:

- Conducted investigations to find people who had been exposed.
- Provided health information in the person's own language.
- Applied and read TB skin tests in homes and gatherings.
- Gave people TB medicines in their homes.
- Arranged for transportation to the clinic.

The team also taught the public health workers some of their patients' social customs so that the workers serving them in their homes or in the clinic knew how to show proper respect and earn trust.



Photo courtesy of Arkansas Democrat-Gazette, Photographer Benjamin Krain Copyright 2005. All rights reserved

Impact:

The work of the Outreach Team in the 2003 outbreak paved the way for the TB program to begin discussions in 2005 with the poultry industry management in Northwest Arkansas about implementing new control measures to screen their new foreign-born employees.

Dr. Iram Bakhtawar, director, TB Section, Division of Health, Arkansas Department of Health and Human Services, said, "The relationship that the team built with these communities helped us to understand them better and allowed the opportunity to use TB control measures best suited to their needs. Over the last couple of years the incidence of TB has decreased in these communities."

Between June 2002 and December 2004:

- Of 1,075 exposed persons identified for 50 suspected cases; 1,013 (94%) were screened for TB.
- Exposed persons that started treatment within 3 days of notification had improved from 33% to 96%.
- Average number of contacts per suspected case increased from 6.8 to 26.9 contacts.
- About 78% of people who got TB completed taking the drug treatment.

The PHHS Block Grant continues to provide funding to purchase regular supplies of TB medicine and stands ready, as the major funding source for TB drugs, to fight the next TB outbreak in Arkansas.

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PHHS Block Grant Dollars Provide Resources Needed to Protect California Communities

Issue:

California epidemiologists were at the heart of handling health problems related to the 1991 derailment of a Southern Pacific tanker that caused 19,500 gallons of liquid herbicide to spill into the Sacramento River. Epidemiologists keep outbreaks of diseases, such as those caused by contaminated food and water, under control and study the impact that diseases, such as diabetes and asthma, have on our states' population.

The California Department of Health Services is tasked with ensuring that experienced epidemiologists are on board to protect the health of communities. The challenges of recruiting, training, and retaining individuals for this important job are significant.

Intervention:

Developed in 1989, California Epidemiologic Investigation Service (Cal EIS) is the first program of its kind offered by state health departments. Block Grant dollars are critical to meeting this need in that there is no other existing source of state or federal funds for this program. The program has stringent criteria for acceptance and clear guidelines for staying in the program.

- Cal EIS provides one to two years of applied training in epidemiology for master's-level epidemiologists. The Cal-EIS is patterned from the Centers for Disease Control and Prevention's Epidemic Intelligence Service.
- Experienced epidemiologists in either a local or state health department serve as mentors for the Cal-EIS Fellows over the 2-year training program.
- Local and state health departments partner with Cal-EIS and provide a stipend to Cal-EIS Fellows employed at their agencies.
- Cal-EIS offers an excellent example of state-local partnerships in that trainees (Fellows) are placed with DHS programs or with Local Health Departments.



Former Cal EIS fellow and veterinarian Michele Jay investigating a Q-fever outbreak in Calaveras County.

Impact:

Cal-EIS has succeeded in protecting our community's health through the placement of qualified epidemiologists.

- Of the 80 Cal-EIS graduates, 57, or 71%, are employed in public health.
- The Cal-EIS program has become a model for the nation and is being replicated in other states, including North Carolina and Florida. This replication creates costs savings for all and strengthens public health across the United States.
- Funds leveraged over the last 6 years: Current Cal-EIS fellows are paid a stipend salary of \$37,000 during the training year, and 100% of these funds have come from county and state public health programs.
- It is estimated that Block Grant dollars have leveraged well over \$1,740,000 in state and county funds over the past 6 years for salary and travel support for Cal-EIS trainees while at the same time providing public health guidance and support for our communities.

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Teens and Green Hornet: Dietary Supplement Leads to Hospitalization

Issue:

Four teenage boys in El Paso County, Colorado, were admitted to Colorado Springs hospitals over the Valentine's weekend 2004 after consuming a dietary supplement marketed as "Green Hornet."

- The product was manufactured by a Florida-based company and was being marketed as a legal version of the illicit street drug "Ecstasy."
- The product was readily available on the Internet and at various retail locations around the country and at least one in Colorado Springs.



Aid was sought from the Colorado Department of Public Health and Environment's Consumer Protection Division in investigating this case, particularly because Green Hornet was suspected of being contaminated.

Intervention:

An FDA analysis of the drug determined that the product contained high levels of two over-the-counter drugs not declared on the product label, a violation of the Federal Food, Drug and Cosmetic Act. The PHHS Block Grant funds provided the resources for the state to accompany the FDA and exercise the state's authority to embargo potentially dangerous products.

Impact:

PHHS Block Grant dollars played an important role in achieving both short-term and long-term impacts:

- The embargo ensured that additional movement or distribution of the product could not occur and enabled FDA to conduct analyses of the product to determine contents.
- The FDA issued a national consumer warning about the use of Green Hornet.
- The use of PHHS block grant funds also permitted the Consumer Protection Division within the Colorado Department of Public Health and Environment to revisit the retailer to facilitate release of the embargo and voluntary destruction of the product in inventory.
- The FDA took further action to prevent the manufacturer from producing this and similar products. As a result of the cooperative actions of the two agencies, this dangerous product was removed from distribution in Colorado. An added benefit was that the manufacture of this product was stopped, thereby eliminating a potential source of future injury or death throughout the nation.

Green Hornet and similar products pose a potential public health concern as they may be marketed as "safe legal highs."

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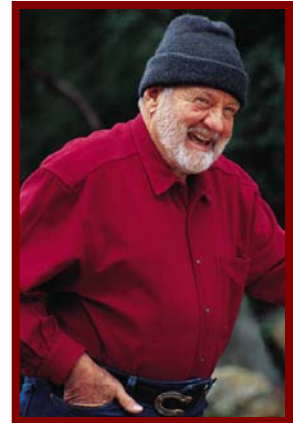
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Connecticut Seniors Standing Tall: How PHHS Block Grant Funds are Preventing Falls

Issue:

More than any other preventable cause, falls cause more older adults in Connecticut to lose their independence and be placed in nursing homes. Falls can also lead to hospitalization and possibly death, costing the state millions of dollars. In Connecticut

- Falls are responsible for approximately 11,000 hospitalizations each year (2002 Connecticut Registration Report).
- Average direct medical cost per hospitalization is \$12,000.
- 70% of fall-related hospitalizations are among persons aged 65 years and older.
- Older adults have a death rate due to falls that is six times that of the state's average death rate.
- At least 30% of community-dwelling adults aged 65 years and older will fall each year.



Intervention:

The Connecticut Department of Public Health's Injury Prevention Program works with local health departments to implement community fall prevention programs for older adults. Local health departments receive an annual allocation from the Preventive Health and Health Services Block Grant to address community health needs, including fall prevention. Each year, three to six local health departments conduct fall prevention programs. Fall prevention activities funded under the PHHSBG focus on decreasing home hazards, improving strength and balance through exercise programs, reducing medication interactions, and increasing awareness of fall risks and prevention among older adults and their families.

- Local health departments, usually in collaboration with home health care agencies, conduct home safety visits to identify fall hazards, such as slipping and tripping hazards, inadequate lighting, and lack of grab bars or railings.
- Home visitors provide safety supplies, such as non-slip mats, night lights, tub chairs and rubber cane tips to older adult participants.
- Home visitors also provide education on how to prevent falls and work with older adults and family members to correct hazards.
- Fall prevention presentations and medication safety reviews, which check prescription and over-the-counter medicines for possible interactions that could lead to falls, are provided in senior centers, housing complexes and other settings.
- Exercise classes for older adults focus on improving strength, balance and flexibility are offered in 4- to 6-week sessions at senior centers and housing sites.

Impact:

PHHS Block Grant funding enables the Department of Public Health and local health agencies to provide critical fall prevention services to older adults in their communities. This is the only funding source many local health departments have available for injury prevention programs. Results from the past four years include the following:

- More than 550 home safety visits were conducted for older adults, and at least 77% of identified fall hazards were corrected on visits.
- 50% of the home safety visit recipients reported falling during the year prior to the visit, while only 3% reported falling at the four-month follow-up after the visit.
- At least 370 older adults participated in exercise classes, with 92% reported continuing to exercise at end of program.
- Approximately 900 persons participated in fall prevention seminars or medication safety review programs. Approximately 87% were able to identify fall risk factors and 79% reported taking action to reduce their fall risks as a result of the programs.
- The PHHS Block Grant is the only funding source to many local health agencies to provide these services, which can prevent nursing home admissions, reduce health care costs, and help Connecticut's older residents remain active and independent members of society.

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Fewer Crowded D.C. Emergency Rooms Lead to Better Health Care, Thanks to PHHS Block Funds

Issue:

Whenever uninsured Washington, D.C., resident, Eric Shropshire, 30, needs to renew his supply of medication for his diabetes, he goes to the Emergency Room (ER) at Greater Southeast Community Hospital. On any day, he is likely to be among an estimated 85% of ER patients who goes to ERs for their basic health care. Due to a 10,000-person (2.57%) increase in ER visits, plus the closing of several major facilities since 2000, District hospitals have faced continued overcrowding.

It is estimated that approximately 300,000 adequately insured District residents (50%) are still experiencing difficulty finding a doctor close to home. This results in poor health, high costs, crowded emergency rooms, more hospitalizations for avoidable conditions, and high rates of disability. About 52% of District residents are said to live in federally designated primary care Health Professional Shortage Areas (HPSAs) and 30% live in federally designated Medically Underserved Areas (MUAs) or populations.

Intervention:

Hoping to steer low-income patients needing basic care away from ERs and into neighborhood clinics, the PHHS Block Grant funded D.C. Area Health Education Center (AHEC) to provide the "Find Yourself Healthy Program." During 2005, AHEC developed a comprehensive training manual and hired peer leaders called "community health navigators" to educate and walk hand-in-hand through the health care system with residents in Wards 7 and 8, two of the poorest areas in the city. Training included basic health information, introduction to opportunities for health care, and assistance in seeking care at nearby clinics.



Having come to the end of its 5-year federal funding period, the AHEC faced extinction unless it could show the value of its health services as well as an ability to continue providing these services based on other sources of funding. The Block Grant "Find Yourself Healthy" Program was critical to AHEC's ability to attract future support and continue providing valuable health care to District communities.

Impact:

- Block Grant funds trained 18 health navigators who helped 1,323 residents, including diabetics like Eric Shropshire, find appropriate care for their health concerns. Because people have begun to use nearby clinics, visits to ERs have been reduced on average of about 80 percent.
- In addition, now that residents have a reliable source of ongoing care, many will avoid developing disabilities and chronic conditions. This will save the District thousands of dollars in health care costs.
- Success of the "Find Yourself Healthy Program" led the District's state governing body to award \$600,000 to AHEC so it can continue to provide health education programs in 2006.
- In addition, the Preventive Health and Health Services Block Grant will continue funding AHEC to help other community organizations build health navigator programs throughout the District of Columbia.

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Shaping Up Public Health in Florida: PHHS Block Funds Move the Sunshine State in Healthier Directions

Issue:

Florida may be known as the sunshine state, but the health of its residents is cloudy. Regardless of age, race, ethnicity, and socioeconomic status, chronic diseases—such as heart disease, cancer, and diabetes—account for 6 of the top 10 causes of death and disability in Florida. Chronic diseases and their risk factors cost the state over \$45 billion in direct medical care and lost productivity. The following diseases cost Florida:

- \$18.6 billion – Cardiovascular disease
- \$14 billion – Cancer
- \$6 billion – Diabetes
- \$3+ billion – Obesity

Although chronic diseases and their disabilities are among the most common and costly health problems, they are also among the most preventable. Policy and environmental changes affect everyone in a community and are therefore the preferred method for health promotion and chronic disease prevention.

Intervention:

Charged with reducing death and disability from heart disease, stroke, diabetes, and other chronic diseases, the Florida Department of Health created the Chronic Disease Health Promotion and Education Program (CDHPE). PHHS Block Grant funds are disseminated through this program and used by all 67 of Florida's County Health Departments to

- Engage community resources and form partnerships to target and develop policy or environmental changes within communities, schools, worksites, healthcare agencies, and other organizations.
- Implement policy and environmental interventions focusing on the top five preventable risk factor areas of the *Healthy People 2010* objectives: heart attack/stroke, diabetes, nutrition/overweight, physical activity, and tobacco.
- Obtain at least a 25% match in resources and buy-in from the local community to use PHHS Block Grant funds.



Impact:

During 2004–2005, **336** policy and environmental interventions were completed across the state. Examples of these successes include the following:

- PHHS Block grant funds helped *Holmes County* to build a rural community's first tennis/basketball court.
- *Jefferson County* Health Department built a softball field for a local middle school with PHHS Block grant funds. The local school board passed a policy to provide ongoing maintenance of the field. This field is used by both the community and the school.
- An *Indian River County* project funded by PHHS Block grant collaborated with local partners to pass healthy vending policy in schools.
- Faith-based organizations partnered with local County Health Department in *Lake County* to establish a policy that will provide parishioners with diabetes education.
- A PHHS Block Grant paved the way for restaurants in *Pinellas County* to develop healthy children's menus.

The increased success of the CDHPE program demonstrates what Florida's state and local governments can make happen with the help of the PHHS Block Grant program.

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How to Get 'em Back: Senior Flu Clinics after a Flu Shortage Season

Issue:

The influenza (flu) vaccine shortage of 2004-2005 had seniors across the nation standing in lines to get vaccinations and led to cancelling many community vaccine clinics in Hawaii. The shortage required allocation of vaccine to high risk populations only, and many seniors were asked to defer flu vaccination. Hawaii data showed that the senior flu vaccination rate fell to 60% in 2004, approximately 15% below rates for 2002 and 2003.

Flu is a major cause of illness, disability, and death in the elderly. A 2001 study conducted by Hawaii's largest health insurer concluded that the estimated cost savings of flu vaccination to seniors (aged 65–75 years) averages approximately \$80 per medical client.

The Flu and Pneumonia Task Force wanted to restore the senior flu vaccination rate during the 2005–2006 flu season. There was concern, however, that healthy seniors, who had been asked to step aside during the previous flu season, might not seek a flu vaccination in 2005.

Intervention:

The Task Force developed a targeted strategy to increase vaccination use in 2005–2006 through vaccine clinics held at the Honolulu Senior's Fair, an annual event that draws over 15,000 attendees each September at the Blaisdell Center Exhibition Hall. The state's two largest insurers (one fee-for-service provider and one HMO) provided free flu and pneumococcal vaccines at the fair to those who had Medicare Part B coverage. These same vaccines were also available for others without Medicare Part B for a small charge.



PHHSBG funds were used to support outreach activities to increase participation in the flu clinics. Activities included direct mail postcards to announce flu clinics, bag stuffers distributed by major retailers, posters, bus cards, radio messages (both mainstream and ethnic) and television spots. Ads in a major newspaper announced incentive items for those who got a flu or pneumococcal vaccine at the Senior's Fair.

Impact:

The 2005 Senior Fair had the highest participation of any flu clinic in over 10 years. During three days, more than 5,100 flu and pneumonia shots were given, primarily to Medicare Part B beneficiaries and the chronically ill. This equates to an overall participation rate of approximately 34% of fair attendees.

The postcards, mailed out by the Task Force to targeted HMO members, were highly successful. The HMO needed to schedule additional staff and vaccine during the event; they plan to use the mailings again in 2006. The use of a fee-for-service health care provider was also extremely successful, and already plans to expand capacity for providing shots in 2006. The Task Force has set a 2006 goal of at least 10,000 shots during the three-day fair.

According to preliminary BRFSS data, the Hawaii senior flu vaccination rate returned to 74% for the period from October to December 2005 and is comparable to pre-shortage rates.

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Idaho Seniors Become “Fit and Fall Proof”

Issue:

William, an 86-year-old Idaho man, moved into an assisted living center because he felt he could no longer live on his own. One of the biggest factors in his decision was the fear of falling and not being able to get up on his own or call for help.

- Idaho's older citizens are more likely to die from a fall than older adults across the country (8.4 deaths per 100,000 in Idaho versus 5.5 per 100,000 in the United States).
- Idaho's EMS system responded to more than 6,000 fall-related calls in 2001-2003. More than half of these calls were from Idahoans over the age of 65.
- Chronic health conditions and taking four or more medications per day increases the risk of falling.

Intervention:

In 2004, the Idaho Injury Prevention Program opened a free exercise program for older adults called “Fit and Fall Proof.” Improving strength, balance and flexibility through regular exercise can reduce falls for many older adults.

- Classes are held for 30–60 minutes twice a week in senior centers, churches, assisted living centers, and gyms in seven local health districts across the state.
- Volunteer peer leaders are trained as exercise class instructors.
- Class participants take a "Get Up and Go" test at the beginning and end of each 6-week session to measure improvements in balance, strength and flexibility.



Impact:

After participating in “Fit and Fall Proof” for one year, William has improved his mobility and balance so much that he has recently moved out of the assisted living center and is living on his own once again. He has also been trained to be a volunteer class leader for the center and serves as a role model to his peers.

By the end of the first year:

- 29 sites across Idaho hosted “Fit and Fall Proof” classes.
- 137 volunteer class leaders were trained to teach classes in their communities.
- Over 300 seniors participated in the “Fit and Fall Proof” exercise program.
- 85% of the class participants that took the "Get Up and Go" tests improved their balance, strength and/or flexibility during the 6-week sessions.

The Idaho Injury Prevention Program continues to receive positive comments from participants about the program, such as the testimonial below:

"Everyone in the class talked about how much they have improved. Flexibility in their hands and balance have increased. One woman in the class had had brain surgery for a tumor. During her surgery her balance nerve was removed, which resulted in her falling about six times per day. Over the last six weeks she has fallen only once! The exercise has also helped her panic disorder that began after the surgery. She felt that being able to talk and work with me was a significant improvement in her life."

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Iowans Dramatically Change Their Lives with The Lifestyle Challenge

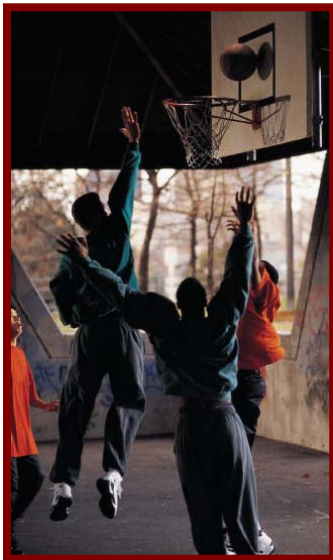
Issue:

With nearly 2 out of 3 residents overweight or obese, a dynamic countywide behavioral modification program was desperately needed in Emmet County, Iowa.

- More than half the population is in the age range 25 to 64 when cardiovascular disease increases.
- An estimated 27% of the county population has undetected high blood pressure.
- 61.2% of county residents are considered overweight or obese.
- In 2001, the initial intervention participants had an average body mass index (BMI) of 30, and 41 percent were at high risk for diabetes, according to a Diabetes Risk Assessment.

Intervention:

An initiative to use a little fun and friendly competition to improve health has grown into a strong community commitment to change lifestyles and community norms. The Iowa Department of Health and Avera Holy Family Health (the county's largest health care system) lead Emmet County's Lifestyle Challenge, which is supported in part by the PHHS Block Grant funds. Several other partners in the state and county collaborate and support the intervention.



Over 10 percent of Emmet County residents have taken part for at least one year of the 5-year program, which began in 2001. High-profile participants, such as the mayor and prominent business persons, bring visibility to the program, and encourage more participation from county residents.

The Lifestyle Challenge emphasizes gradual weight loss through improved food choices, regular physical activity and a lifetime of healthy behavior. Educational sessions, support groups and positive reinforcement are keys to the success of this intervention. Teams of five participants set their own physical activity goals, and track the amount of time they spend exercising. Health data collected over five years for the participants (including monthly weight checks with a registered dietitian) are shared confidentially, and provide a long-term record of progress.

Impact:

Collectively, the community has lost over 9,060 pounds and recorded 53,800 hours of physical activity through the Lifestyle Challenge.

- The average weight loss per person was almost 8 pounds in 2005.
- The average amount of physical activity recorded increased from 27 hours to 47 hours per person from 2001 to 2006.

The collaboration has noticed a gradual shift in community conversations from that of short-term diets to lifestyle changes for long-term health.

The Lifestyle Challenge has expanded in the county each year since its inception, and has generated positive support from local media and opinion-leaders. In 2004, Fort Collins, Colorado, Mount Pleasant, Iowa, and Columbus, Indiana adopted the Lifestyle Challenge initiative and have had similar program success.

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Fighting Obesity in Barber County: A Community Wins by Losing

Issue:

Obesity in Kansas continues to jeopardize the future of health care and quality of life for individuals, communities, and businesses. Poor eating habits and a lack of adequate physical activity are the primary contributors to this problem and are directly linked to hypertension, type 2 diabetes, coronary heart disease, stroke and certain types of cancer. Data illustrate the destructive nature of this condition in Kansas.

- Kansas spends an estimated \$657 million annually in medical costs associated with obesity.
- Since 1992, the prevalence of obesity has increased by 70% among Kansas adults.
- By 2020, one in every four dollars spent on health care will pay for obesity-related treatments.

Thousands of Kansans battle obesity. Janet, a woman in Medicine Lodge, Kansas, is a prime example of an individual struggling because of excess weight and the medical conditions associated with being obese. For years, Janet's lifestyle involved low activity and a poor diet. Janet experienced difficulty breathing, walking up stairs and performing routine tasks, such as shopping for groceries. At age 56, Janet was diabetic and morbidly obese, weighing 400 lbs.

Intervention:

In the winter of 2005, in an effort to address the rise in obesity in the town of Medicine Lodge, Kansas, the local health department created the Community Meltdown program. The Meltdown reflects the community's desire to help Janet, and others like her, melt away pounds of fat through exercise and education. Funded by the Preventive Health and Health Services (PHHS) Block Grant as part of the Chronic Disease Risk Reduction grants administered through the Kansas Department of Health and Environment, the program includes the following:

- Six weeks of evening meetings.
- Regular weigh-ins, hypertension, and blood lipid screenings.
- Educating participants on the causes of overweight, including information on the role of proper physical activity and nutrition and the harmful effects of tobacco.



Impact:

Wanting help, but unsure and embarrassed about seeking assistance, Janet responded to an advertisement in the local newspaper about the Community Meltdown. In January 2005, Janet confronted the stigma of being obese and began participating in the program. With the help and support of the program's many partners, she reached her goal. Today, she has lost approximately 100 lbs. Janet is able to shop for her own food and continues her efforts to become healthier.

In addition to Janet, 48 other residents of Medicine Lodge participated in the program. The success of the program means exciting progress in 2006, including

- Expanding the program to include two additional Barber County communities.
- Expanding the program to include families and youth.
- Increasing the number of participants in the Medicine Lodge program each year.
- Supporting participants to quit smoking with the Kansas Tobacco Quitline Fax Referral Form.

Giving individuals, like Janet, the tools and support to lose weight and practice life long healthy habits will ultimately reduce the costs associated with obesity and provide an the opportunity for Kansans to live healthier and more satisfying lives.

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Helping the Uninsured in Kentucky

Issue:

Overweight, diabetic, high blood pressure and no health insurance describe many of Kentucky's 576,500 uninsured, and that is about 14.3% of the state's population.

- 35% do not have a medical home, which increases the likelihood of poorer health outcomes.
- 13% cite the Emergency Room as their regular caregiver.
- Many report they lack the necessary resources to purchase prescribed medications.

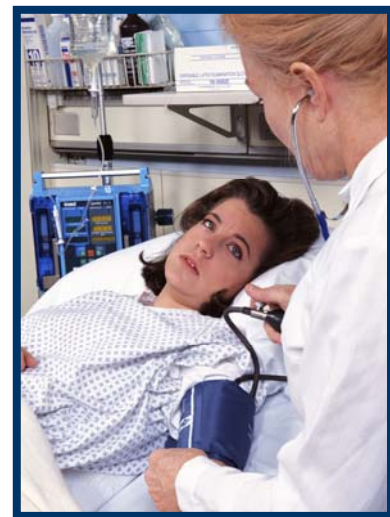
Pharmaceutical companies have Patient Assistance Programs available for low-income persons but the complicated paperwork and frequent rule changes leave many individuals with no means of getting needed medications.

Intervention:

Over the past two years, \$75,000 of the Preventive Health and Health Services Block Grant funds have gone to Health Kentucky, Inc., a nonprofit charitable organization that coordinates a statewide network of volunteer providers through the Kentucky Physicians Care program. The Kentucky Physicians Care provider network includes physicians, dentists, pharmacies and pharmaceutical companies. Health Kentucky, Inc. works in collaboration with other public and private organizations that address the health-care needs of the poor and uninsured.

Health Kentucky, Inc. provides

- Public awareness campaigns using radio, television spots and signage and,
- Provider recruitment through the awareness campaigns targeting medical audiences.



Impact:

In 2004, there were 41,710 uninsured Kentucky residents enrolled in the Kentucky Physician Care Program. The program provided eligible clients 2,507 referrals for free services to participating physicians, dentists and pharmacies through the toll free Kentucky Physicians Care Hotline. About 97,799 free prescriptions were filled at participating pharmacies with a value of \$9,642,208.

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Preventing a Tuberculosis Nightmare after Hurricane Katrina

Issue:

A widespread tuberculosis outbreak in Louisiana was what CNN predicted after Hurricane Katrina. Leadership at the state tuberculosis (TB) control program knew they had to act quickly and efficiently to prevent this potentially deadly outbreak. If untreated, a person with TB in the lungs can spread the contagious disease easily through the air by coughing, sneezing, or even talking. In the nightmarish aftermath of Hurricane Katrina, 137 clients with infectious tuberculosis had evacuated, and their whereabouts were unknown. Four out of eight TB staff in Louisiana had also evacuated, and state laboratory and pharmacy offices were destroyed.

- One person with active tuberculosis will infect 10 to 15 people each year if not treated.
- Louisiana has the 10th highest rate (5.6/100,000) of TB in the United States (4.9/100,000).
- Health care cost for TB is \$703.1 million/year; total cost is over \$1 billion for the United States.
- Tuberculosis costs Louisiana \$11,500 per patient annually.
- Preventing and curing TB has been possible thanks to Preventive Health and Health Services Block Grant (PHHS Block Grant) funding over the years.

Intervention:

Tuberculosis staff who could remain in the state set up temporary command centers at parish health units in north and south Louisiana. Neighboring states and medical supply firms were contacted by telephone, fax, and email to help Louisiana reestablish its TB operations. A list of patients with TB was compiled from the registry taken from the New Orleans state public health office. Health departments nationwide were on the watch for patients who sought refuge at shelters. Tuberculosis staff across the country and public health advisors from the Centers for Disease Control and Prevention used the list to cross check names on shelter registration lists.



- Persons found in shelters were given medical attention and isolated, if needed.
- Texas Department of State Health Services staff performed laboratory analysis on all tuberculosis samples from Louisiana.
- VersaPharm, a pharmaceutical company, donated all needed medications to Louisiana.
- Illinois (Suburban Cook County) donated a mobile unit bus to conduct clinics.
- Alabama State Health Department donated a portable x-ray machine.
- Louisiana laboratory staff began to run liver function tests three weeks after the storm.

Impact:

PHHS Block Grant funds have allowed Louisiana to maintain a tuberculosis control program equipped to adequately handle what could have been a widespread outbreak of TB. This kind of dynamic, locally defined funding proved invaluable in preventing a TB nightmare in Louisiana.

- 137 clients with TB were located across the country and no outbreaks occurred.
- Tuberculosis clinics have resumed in some parts of the evacuated areas in Louisiana.
- States have picked up the cost of care for evacuated clients with tuberculosis.

Sources: 1.) American Lung Association, <http://www.lungusa.org>; 2.) World Health Organization, <http://www.who.int>; 3.) Centers for Disease Control and Prevention <http://www.cdc.gov>, <http://www.cdc.gov/mmwr/PDF/wk/mm5310.pdf>; 4.) Louisiana Department of Health and Hospitals, Office of Public Health, Tuberculosis Control Program <http://www.oph.dhh.state.la.us/tuberculosis/index.html>

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Worcester County, Maryland Loses Big Thanks to Preventive Health and Health Services Block Grant Funding

Issue:

There are 1,440 minutes in a day, and yet 38.6% of Americans participate in no leisure time physical activity, contributing to the 400,000 lives lost each year due to poor diet and physical activity behaviors. Worcester County, Maryland is not exempt from the impact of poor eating and physical activity habits as a recent community health survey revealed (PRC Community Health Survey, 2004):

- 11.4% of residents have chronic heart disease compared to 7% of the U.S. population.
- 13.5% have diabetes compared to 8.7% of the U.S. population.
- 39.6% have high blood pressure compared to 29.4% of the U.S. population.
- 33.8% have high cholesterol compared to 25.1% of the U.S. population.
- 44.9% are sedentary compared to 38.6% of the U.S. population.

Programs to help Worcester County residents become more physically active are necessary to help reduce the risk and burden of chronic diseases for taxpayers.

Intervention:

Participation in regular physical activity can help reduce the risk of heart disease, high cholesterol, high blood pressure, type 2 diabetes, and osteoporosis. The Worcester County Health Department uses PHHS block grant funds to provide two physical activity programs for county residents. This funding pays for staff, equipment, advertising, education materials, and program incentives. A description of one of the programs follows.

Lunch Time Fitness Express is a weight bearing physical activity and nutrition program offered 3 days per week, 30 minutes per session, in 8-week cycles. It is taught by staff of the Worcester County Health Department and held at the Worcester County Recreation Center in Snow Hill, Maryland. To assess program effectiveness, all participants complete baseline measurements including

- body mass index
- body fat
- calcium and vitamin D rich food intake levels
- current level of participation in weight bearing physical activity

These measurements are repeated at the program's conclusion and again six months after completion of the program to determine if participants have been able to make long-term changes for nutrition and physical activity.

Impact:

With a relatively low cost of \$32/per participant per 8-week cycle, the *Lunch Time Fitness Express* program achieved the following results since July 2005:

- 5.5% decrease in Body Mass Index (BMI) which aids in reducing the risk for chronic diseases
- 4% decrease in Average Body Fat (ABI)
- 20% improvement in participation in weight bearing physical activity
- 54.5% of participants reported continuation of changes in nutrition and physical activity habits at 6-month follow up.

PHHS block grant funds are necessary to help expand and continue to offer effective physical activity programs for residents of Worcester County, Maryland.

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Federal Money Funds Brighter Future for Rape Survivors

Issue:

The 17 Massachusetts Rape Crisis Centers are still reeling from 3 years of devastating state funding cuts. "Sex Offense Set-Aside" money, part of the Preventive Health and Health Services Block Grant, has helped keep the Rape Crisis Centers open during the state's fiscal crisis.

It is difficult to measure the incidence of sexual assault in the Commonwealth for a variety of reasons. The most reliable estimates conclude there are currently about 552,512 adult and 64,138 adolescent survivors of sexual assault in Massachusetts. Of the adult survivors, 90,044 are women with disabilities.

Research has shown an association between sexual assault and a number of health issues. These include post – traumatic stress disorder, drug and alcohol abuse, eating disorders, relationship and mental health problems, and in some cases suicide. Nationally, the annual medical cost to victims of rape, not including childhood sexual abuse, is \$127 billion.

Intervention:

The \$840,584 in federal Block Grant funds have played a pivotal part in reducing these impacts on individuals and families across Massachusetts. This represents about 11% of the total operating budgets for the Rape Crisis Centers. The following services are provided confidentially by trained, skilled professionals in 17 Rape Crisis Centers across the state:

- Linking people to needed services.
- Providing client counseling and advocacy services, including medical, legal and police advocacy sessions.
- Helping provide 24-hour sexual assault hotlines in English and Spanish.
- Supporting these Centers' activities to increase accessibility and awareness of services.
- Staffing Department of Public Health efforts to partner with other agencies to prevent sexual assault; supporting a competent work force on the local level through training and program development; and evaluating programs to assure effectiveness.



Impact:

Preventive Health and Health Services Block Grant funds save lives and families, restore futures, and, in the long run, are investments that pay a high return to the state and to local communities. In Massachusetts last year, they helped fund

- Education activities to **45,547** individuals.
- **8,203** counseling and advocacy sessions to **1,944** clients.
- Emergency 24-hour hotline services through **11,183** phone calls.

As rape rates rise, it is essential to combat these crimes with increased prevention and education efforts and to continue providing access to quality services for survivors in a safe setting.

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More Walkable Communities Lead to More Healthy People in Minnesota

Issue:

Despite the benefits of physical activity, the majority of people in Minnesota are sedentary.

- 51% of Minnesota adults report not meeting the recommendation for moderate physical activity of 30 minutes/day
- 16% of Minnesota adults report no leisure time physical activity

The health care costs for a sedentary population are significant.

- An estimated \$495 million were spent in 2000 in health care costs that would have been avoided if all Minnesota adults met the physical activity recommendation

A large number of Minnesota communities are not walkable, making it difficult for people who choose to walk for transportation or recreation. Even in communities with sidewalks, walkways are sometimes in such disrepair that it makes it difficult to walk and impossible to navigate with a wheelchair or baby stroller.

Intervention:

Communities in Minnesota are in search of effective strategies to increase physical activity for their residents and workers. In 2004, experts from the National Center for Bicycling and Walking (NCBW) were brought to Minnesota to conduct 11 workshops. Eight were held in the Minneapolis/St. Paul metropolitan area, and three were held in Isanti County. Results of Walkable Community Workshops include a community walkability assessment and action plan.



With assistance from NCBW, the Minnesota Department of Health, supported by Preventive Health and Health Services (PHHS) Block Grant funds, developed a protocol to train in-state experts on how to conduct Walkable Community Workshops. The training protocol was pilot-tested in two Minnesota communities in October 2005. The workshops successfully engaged community members to develop walkable community action plans. The training protocol is being finalized and statewide trainings will begin in summer 2006.

Impact:

- By training in-state staff to conduct Walkable Community Workshops, the cost savings for each community will be \$2,500 per workshop.
- Nearly 100,000 people living in the two communities where the workshop training protocol was pilot-tested will benefit from a more walkable community.
- The long-range plan is to conduct Walkable Community Workshops in many Minnesota communities so that people all across the state may benefit from more walkable communities.

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Bringing Brighter Smiles to Mississippi Thanks to PHHS Block Grant Funding

Issue:

Dental caries cause a great deal of pain, cost a lot of money, and can be prevented. The problem only gets worse when people have limited or no access to dental care in their communities.

- Mississippi has 1,176 active dentists, or about 1 dentist per every 2,400 persons. Less than half of these dentists accept Medicaid.
- Children living in poverty suffer double the amount of tooth decay and pain, but are only half as likely to obtain a dental visit as their affluent peers.

Water fluoridation is the cost effective method to preventing dental caries in communities throughout the state. Fluoridated water strengthens the enamel of teeth and makes them more resistant to decay. It also inhibits the bacteria that cause tooth decay and, most importantly, requires no consumer effort.

- Water fluoridation can reduce dental caries by 20% to 60% in people of all ages, regardless of socioeconomic status.
- Every \$1 spent on community water fluoridation saves \$80 in dental treatment costs.
- Only 46% of Mississippi's residents receive fluoridated water through their local water system, well below the national health objective rate of 75%.



With a shortage of dentists in the state and limited access to dental care for the uninsured and underinsured, community water fluoridation is more important than ever.

Intervention:

The Mississippi Health Department leveraged Preventive Health and Health Services Block Grant (PHHS) Block Grant dollars to acquire additional funding for water fluoridation and to form a public-private partnership. This partnership has

- Provided 26 communities in Mississippi with new public water fluoridation systems. These new systems have an estimated average ongoing cost of less than 50 cents per person per year.

PHHS funding also funded the following critical programs in Mississippi's schools:

- A statewide oral health survey by the Regional Oral Health Consultant of third grade children enrolled in Mississippi's public elementary schools.
- A weekly school fluoride mouth rinse program in 103 elementary schools, serving 29,619 children in grades K - 6.
- 47 oral health screening/education events at various locations, including state agencies, community colleges, and public schools.

Impact:

The Mississippi Health Department has made great strides towards improved oral health in the state with Preventive Health and Health Services Block Grant funding

- 154,000 more people in Mississippi now have fluoridated water.
- \$368,310 were spent on community water fluoridation, resulting in a projected savings of \$29,464,800 in dental treatment costs.
- 1.55 million or 50.5% of Mississippi's total population now receive fluoridated public water.
- Mississippi received multiple State Fluoridation Awards at the National Oral Health Conference in 2005 in recognition of these successes.

Thanks to PHHS Block Grant dollars, more people in Mississippi can smile with healthy teeth.

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Missourians with Diabetes are Urged to Take Care of Their Feet for Life

Issue:

Having a foot amputated is a serious risk for people with diabetes. According to the American Diabetes Association, a person with diabetes is 10 times more likely to require a foot amputation than a person without the disease. To prevent such a catastrophic loss, good foot care and regular foot exams are essential so problems can be treated early and effectively. But in Missouri—where more than 315,000 people have been diagnosed with diabetes—that message was not reaching those who needed to hear it the most.

- Although diabetes prevalence is higher among African Americans in Missouri, a lower percentage of African Americans perform daily self-exams of their feet, according to 2003 state surveillance data.
- From 1999 to 2003, African Americans in Missouri were hospitalized for lower-extremity amputations at a rate of 6.6 per 10,000 people, compared to a rate of 2.1 per 10,000 people for whites. Hospitalization costs for lower-extremity amputations in Missouri totaled more than \$61.5 million in 2004.
- The foot care message is especially important in St. Louis and Kansas City, where a large number of African Americans live.

Intervention:

To take the message to the people, the Missouri Department of Health and Senior Services used PHHS Block Grant funding to develop and fully fund a marketing campaign to increase foot self-exams among African Americans. The “Feet for Life” Diabetes Foot Care Campaign was conducted during the summer of 2005 with St. Louis as the primary focus and Kansas City as the secondary focus.



- Forty-five billboards were placed along major highways in St. Louis. An estimated 520,000 people traveled past the billboards every day. The billboard design featured four pairs of feet clad in varied shoe styles – from sandals and suede oxfords to well-worn tennis shoes – representing the diversity of people who deal with diabetes. In addition to the foot care message, the billboard displayed a toll-free telephone number that people could call for additional information and a free fact sheet.
- More than 430 miniature versions of the billboard were placed on St. Louis buses – 83 on the back of buses and 350 inside the buses. While the campaign was conducted during July and August, many of the bus cards were still in place through October. The bus cards had an estimated monthly reach of 2.1 million riders.
- Newspaper ads similar to the billboard design were placed in three African American newspapers in St. Louis City and North St. Louis County. The combined circulation of those newspapers reached nearly 300,000 subscribers.
- Two major pharmacy chains in St. Louis distributed 3,000 diabetes foot care fact sheets at 25 pharmacies by placing them inside bags containing diabetes prescriptions.
- A public service announcement emphasizing the importance of foot care for people with diabetes was broadcasted by radio stations statewide with an emphasis on African American stations in St. Louis and Kansas City. A total of 5,480 radio spots ran in the state's two largest urban areas, reaching approximately two million listeners. Recognizing the importance of the message, state radio broadcasters provided additional spots free of charge with a value of more than \$413,000.

Impact:

By using a variety of media—billboards, bus boards, newspaper ads, pharmacy bag inserts and radio spots—the “Feet for Life” message was seen and heard by a large and varied audience.

- The campaign reached **more than six million people**, primarily in St. Louis and Kansas City, where Missouri's African American population is concentrated.
- The Missouri Diabetes Prevention and Control Program developed new partnerships with major pharmacy chains that will provide useful in future diabetes education campaigns.

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Minorities in Rural Nebraska Take Charge of Their Diabetes

Issue:

Diabetes costs Nebraskans dearly, even those who have not been diagnosed with the disease. Diabetes-related spending in Nebraska was estimated at \$792 million in 2002, including \$552 million in direct costs and \$240 million in indirect costs.

- Diabetes can cost a person their eyesight, their kidneys, their feet (through amputation) or even their life.
- Lifelong disability, caused by diabetes, can make it hard to hold a job or support children. The cost of the uninsured is passed on to others in the community who use the health care system.
- Compared to the white population, Hispanics are 1.6 times, African Americans are 2.5 times, and Native Americans are 3.8 times more likely to die from diabetes.
- A simple blood test for Hemoglobin A1c shows how well diabetes has been controlled using diet, exercise and careful management of blood glucose (sugar) levels over the previous two or three months.
- In 1999, the average A1c test value of clients with diabetes served at Panhandle Community Services (PCS) in Scotts Bluff County was 8.5%.
- In general, every percentage point drop in A1c blood test results reduces the risk of eye, kidney, and nerve diseases complications of diabetes by more than one-third.

Intervention:

Nebraska invests \$12,000 of PHHS Block Grant funds per year to allow PCS to improve the diabetes self-management skills of minority clients in Scotts Bluff County.

- PCS educates minority clients through culturally and linguistically appropriate presentations, one-on-one sessions, small group sessions, monthly and quarterly classes, and quarterly outreach support group sessions.
- The services complement and augment the quality clinical care the clients receive from trained medical professionals. Clients also receive medication, monitors and test strips.

PCS used A1c test results as a way to encourage their clients to take their blood sugar tests, eat right and exercise regularly.



Photo by Robert Holsinger

Impact:

During 2005, PCS served 469 diabetes clients at the clinic and 297 through community screening, 63% of whom were Hispanic or Native American.

- There were four times more clients in the PCS diabetes registry than in 1999 when the county served just 115 persons with diabetes. Despite this large increase in patient load, clients still received quality care, with 89.7% of clients receiving one A1c test and 70.2% receiving two tests per year.
- A1c test values continue to decline, now averaging 7.4%.
- With proper patient education, care and support, up to 90% of diabetes blindness could be prevented, diabetes-related kidney failure could be reduced by 50%, and up to 50% of lower limb amputations could be avoided each year.

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Nevada's Rural Nurses Provide Critical Health Care Services with Block Grant Funds

Issue:

Community Health Nurse (CHN) Veronica Galas went to a local senior center one day to perform routine blood pressure (BP) screening. What she saw that day was anything but routine. An elderly man who regularly saw this Community Health Nurse looked quite differently. He had a one-sided facial droop, with one eye constantly open. Tears flowed from the opened eye, down the man's weathered face, forming a small puddle on the table in front of him. His blood pressure was 190/110.



Upon further review, a senior center staff member reported that this man had had a stroke two weeks before this visit. At that time, the senior went to the nearest emergency room, but left against medical advice. His reason was that he had a doctor's appointment with the Veteran's Administration (VA) Hospital in Reno the next day and received a letter stating that the VA would not schedule future appointments if he did not cancel his

appointment with a 24-hour notice. This man got into his car after having a stroke and drove to his other appointment.

Unfortunately, this man's situation could be a reality for other senior citizens in Nevada.

- Heart disease and stroke combined are the number one killer in Nevada, responsible for 35% of total deaths.
- Cardiovascular disease is responsible for 6,578 hospital inpatient stays in 2001 in Nevada and cost the state \$165 million – approximately \$25,000 per patient. (University of Nevada—Las Vegas, Personal Health Choices, October 2002). The cost does not include outpatient rehabilitation.

Intervention:

The Community Health Nurse explained to the senior that he would likely need to be hospitalized. She assessed the senior's state of mind and determined if anything would prevent him from agreeing to be hospitalized. The two discussed issues that might get in the way of his agreement and solved any problems that prevented him from getting the much-needed care. The CHN then provided transportation for this man to the emergency room.

This man's story illustrates how essential the role of the Community Health Nurse is in Nevada's rural communities. These nurses are often the primary provider for rural Nevadans. The simple intervention of a blood pressure screening is only one facet of the Community Health Nurses' role. At 16 rural sites, Community Health Nurses also provide

- Adult and childhood immunizations
 - Tuberculosis follow-up and direct observation therapy
 - Sexually transmitted disease prevention, testing and treatment
 - Communicable disease investigation
 - Family planning services
 - Well child exams, school health promotion and education, and referral for children with special health care needs.
- Some Community Health Nurses even serve as the county health officer and are a valuable link to social services and specialist medical services.

Impact:

Fortunately, through screening and follow-up efforts, the elderly man's health problems now have a positive outcome. He did go to the emergency room and was admitted to the hospital for treatment. His blood pressure was 134/66. His eye that did not close has stopped its dramatic tearing and regained some muscle control.

Through Preventive Health and Health Services (PHHS) Block Grant funding, Community Health Nurses can perform their critical duties in rural Nevada.

- For State Fiscal Year 2005, Community Health Nurses conducted 3,500 BP screenings throughout rural Nevada.
- Approximately 21% of the population sought out the Community Health Nurses for services in fiscal year 2005.

PHHS Block Grant funding has proven vital to enabling Nevada to adhere to locally defined needs and consequently provide critical medical care to rural Nevadans.

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HealthEASE Improves Lives of Thousands of New Jersey Seniors

Issue:

One older diabetic woman had not gone to a doctor in years because she didn't know how she would pay for the appointment. Another woman would not go anywhere that didn't have grab rails in the restroom for fear her limited mobility would leave her stranded on the seat. A third woman was concerned about her husband's memory problems but didn't know where to get help.

Like many older adults, these women faced barriers that kept them from using existing preventive health services. Unfortunately, providers had been unsuccessful in reaching them because of competing agendas, funding limitations and a lack of administrative coordination. As a result, preventive services were underused.

- In New Jersey, only 34.4% of men and 34.6% of women 65 and older are getting the selected preventive services provided, recommended, and covered by Medicare.
- As a result, in 2002, there were approximately 85,500 preventable hospitalizations among older adults, resulting in roughly 625,000 hospital days and increased costs to taxpayers.

Intervention:

The New Jersey Department of Health and Senior Services recognized the need to build local partnerships between the aging and healthcare systems in order to increase older adult access to health information and services. Preventive Health and Health Services Block Grant funds and a Robert Wood Johnson Foundation grant were used to create *HealthEASE*. This pilot program established partnerships in two counties, Bergen and Ocean, which helped create and deliver health screening/advice events and a 12-session physical activity program for seniors, and health education modules for allied health professionals on six topics of interest to seniors. These programs were promoted by the partnerships and held in community centers, senior centers, town halls, church halls and easily-accessible sites.



Impact:

HealthEASE drew seniors into the healthcare system through its screening and education programs. During the 2-year pilot, over 3,000 screenings were completed at 18 separate events. About one-third of the screenings resulted in abnormal findings and these individuals were advised to follow up with their primary health care provider. Those who participated in the physical activity program demonstrated improved mobility, reach and balance at the end of the 12-session course. The physical activity and education programs were showcased at a statewide conference and 80% of attendees said they were interested in replicating one or more of the programs in their communities. Perhaps the greatest measure of this program's success, however, is its impact on the individuals who participated, including the three women noted above.

- After participating in *HealthEASE* programming, the woman without a doctor was linked by her Area Agency on Aging to a health care provider who is helping her manage her diabetes. The woman with limited mobility joined, and now leads, a physical activity program. After attending an education session called "Keeping Your Mind Sharp," the woman concerned about her husband's memory lapses recognized the severity of the decline and sought additional medical help for him.

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PHHS Block Grant Is Life Support for New Mexico's Rural EMS System

Issue:

The vastness of rural New Mexico means solitude and tranquility to some, but in a medical emergency, it can mean an hour or longer trip to a hospital. Responding quickly and competently requires that the volunteers who make up nearly 80 percent of New Mexico's rural emergency medical responders must have access to state-of-the-art training and equipment.

- New Mexico's three regional Emergency Medical Services (EMS) offices each cover a geographic area about the size of Kentucky. The only Level 1 trauma center (certified to handle all types of medical emergencies) is in Albuquerque, a 4- to 5-hour drive from some locations in the state.
- EMS is the only health care service that is universally available to all of New Mexico's 1.9 million residents regardless of ability to pay.

Intervention:

The New Mexico Department of Health's EMS system is as an essential public health and safety service that has become an integral and valued part of life in all rural and frontier communities, tribes, and municipalities throughout the state. The state's system has been recognized nationally for such progressive enhancements as

- Some EMS personnel provide child car seat installations and make home-safety visits to new parents.
- EMS units sponsor bicycle helmet rodeos and organize farm safety programs.
- EMS personnel participate in public health immunization programs and a new program for stroke prevention and early intervention, along with other public health prevention and preparedness activities.



Impact:

New Mexico's investment of PHHS Block Grant funding has allowed the state health department to generate significant state, private, and other federal funds to support EMS statewide. In addition, Advanced Life Support training mannequins, Pediatric Advanced Life Support equipment and portable cardiac defibrillators have been purchased with grant and matching funds.

Every year, the New Mexico Department of Health's Bureau of Emergency Medical Services:

- Examines, licenses, and provides regular continuing education to more than 7,000 First Responders, Emergency Medical Technicians, and Emergency Medical Dispatchers.
- Inspects, certifies, regulates, and supports about 400 municipal and county EMS services, 19 air ambulance services, and 70 public dispatch agencies.
- Supports three regional EMS offices that provide first-line support, technical assistance, specialized training, and innovative programs.

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Healthy Children ~ Healthy Futures. Serving the Children of Farm Workers in New York State.

Issue:

One of the harshest challenges faced by low-income farm working families, especially migrant farm working families, is obtaining reliable and affordable health care for their children. Farm working families enrolled in the Agri-Business Child Development Program in New York State report many barriers to securing health care for their children, such as:

- The navigation of complicated health care systems and a limited understanding of critical health care issues. *The highest level of education attained in 65% of their households is less than a high school diploma/GED.*
- The ability to access affordable health care services provided in the language of the family and available during hours suitable for farm working families, *74% of which are of Hispanic/Latino descent and in 70% of the households, English is not the primary language.*
- Lack of transportation to and from appointments as most live in rural areas with no public transportation.

Intervention:

Agri-Business Child Development (ABCD) is committed to alleviating barriers to health care for New York State's farm working families. ABCD operates 13 child development centers across the state. In 2005, the agency worked with over 1,500 children ranging in age from 6 weeks old to 5 years old. Each child's health care needs are met on all levels including physical development, dental health, mental health and nutrition. Services are provided in the language of the family, and agency staff help ensure that the entire family is connected to health services in their community.

Each ABCD Center employs a Health and Disabilities Coordinator to monitor and assess the children's development. This Coordinator also implements the Parent Health Education Training Plan. Preventive Health and Health Services Block Grant (via Migrant and Seasonal Farm Worker Health Program) dollars off-set a portion of the Health and Disabilities Coordinators' salaries.



The Health and Disabilities Coordinator in each ABCD Center

- Compiles a health history for every child including but not limited to a physical examination, immunization records, dental, and nutrition information.
- Helps families connect to community health services provided in their language and available during hours suitable for farm working families.
- Implements the Parent Health Education Training Plan using materials that are appropriate for the language and literacy level of the families.
- Arranges transportation and translation services for medical and dental appointments.
- Coordinates the services of other community agencies such as insurance enrollment and dental clinics at the center whenever possible.
- Participates in local health fairs with other community health agencies.
- Serves as a case manager for children with special needs.

Impact:

Of the 1,500 children served by ABCD in 2005

- 100% of the children were identified as having a medical home and receiving designated well child care visits within 90 days of entrance.
- 97% of enrolled children were up-to-date on a schedule of age appropriate preventive and primary care by the end of the enrollment year.
- 98% of the families participated in health education workshops presented at ABCD Centers.

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Caldwell County Residents Breathe Easier While Dining

Issue:

Have you ever gone to a restaurant and seen a young child being forced to breathe in smoke-laden air from the patrons smoking nearby? Have you ever watched a restaurant employee struggle to breathe while serving a table of smokers?

- Secondhand smoke causes approximately 3,000 lung cancer deaths and 35,000–62,000 heart disease deaths in adult nonsmokers in the United States each year according to the American Lung Association.
- Each year, more than 440,000 Americans die prematurely from smoking-related diseases. Countless other family members, friends, and co-workers are also affected by these untimely deaths.
- According to recent statistics for North Carolina, 22.5% of adults and 27.3% of high school students smoke. Approximately 27.7% of adults and 29.8% of high school students in Caldwell County are smokers.
- Tobacco use is the single leading cause of preventable illness and death in the United States.
- The cost of healthcare for smokers continues to spiral, and taxpayers are forced to fund those covered by Medicaid and Medicare.
- Costs suffered by businesses and restaurants to accommodate smokers include the need for more frequent interior refurbishing, the need for more expensive ventilation, and the cost of cleaning up after smokers. Another hidden cost is the constant exposure of employees to secondhand smoke, which accounts for illness and days lost on the job.

Intervention:

The Caldwell County Health Promotion Program, with support from PHHS Block Grant funds, administered through the North Carolina Statewide Health Promotion Program, began partnering with local business owners and Healthy Caldwellians (the Caldwell County Healthy Carolinians Task Force) in 2002 to make positive changes in the local community



- Local restaurants and businesses were surveyed to identify those that offered a smoke-free environment.
- The Health Promotion staff developed a media campaign promoting smoke-free environments, including billboards, newspaper ads, and local TV programming.
- The partnership met with restaurant and business owners to explain the benefits of a smoke-free establishment. When owners made the decision to be smoke-free, they were presented with a framed certificate to display and window clings to announce their smoke-free status.
- The partnership published and distributed a Smoke-Free Dining Guide, updated annually.
- The Health Promotion staff monitors existing smoke-free businesses to ensure policy changes are sustained and advocates for additional businesses to adopt smoke-free policies.
- The Health Promotion staff works with partners to secure grant funding to support and expand the program.

Impact:

- Caldwell County, with a population of 78,548, now has more than 50 choices for smoke-free dining.
- Business and restaurant owners have benefited from eliminating secondhand smoke for employees and patrons by increased profit margins.
- Residents are urging other businesses to adopt smoke-free policies.
- Through the use of PHHS Block Grant funds, the Health Promotion staff and partners have stimulated policy changes and a public attitude change.

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Raising the Physical Activity Bar for Adolescents in Hettinger, North Dakota

Issue:

"Our students were becoming couch potatoes right before our eyes! We were not meeting the state requirements for the number of minutes for physical activity per week. The number of students taking more than one study hall was also increasing," said a Hettinger High School staff member. It was time to make physical education a priority in the southwest North Dakota school's curriculum because

- Hettinger High School required only a half credit of physical education, one-third below state requirements.
- Only 53% of all North Dakota high school freshmen attended physical education classes on one or more days in an average week according to the 2005 North Dakota High School Youth Risk Behavior Survey.
- More alarming to school and community personnel, this percentage dropped to 37% for seniors statewide.

Intervention:

The Hettinger Coordinated School Health team (CSH) proposed changing graduation requirements so that each student in Hettinger (grades 9-12) would need to take 1-1/2 credits of physical education. This recommendation was based on a Preventive Health and Health Services Block Grant funded scientifically-based assessment and planning tool that found:

- The number of minutes the students participated in vigorous or moderate physical activity was inadequate.
- Physical Education staff needed more professional development offerings.
- The facilities (such as the swimming pool, the community bowling alley, and the school's fitness center) were not being used to their fullest potential to enhance physical education class offerings for lifetime fitness activities.
- Students were well below average strength, flexibility, and body composition.



Impact:

Based upon this data, the CSH team proposed a change in policy, which the school board adopted.

- The new policy increased the physical education requirements by 26%, or from a half credit to 1-1/2 credits. (A half credit was equivalent to 52 minutes of daily physical education for one semester.) Hettinger High School students are now required to take three semesters of daily physical education classes.
- The change in board policy has affected 160 students in grades 9–12.
- These changes were so well-received that classes that drew an average of five students now have more than 20 students.
- The number of class offerings has tripled since 2004; strength and conditioning, fitness/aerobics and lifetime activities and other classes have been added.
- To meet the rising demand of students wanting to take physical education classes above the required hours, an extra period of physical education will be offered before school hours during the 2006-2007 school year.

"Since we have made the changes, we have seen wonderful results in the areas of fitness. Our students want to use the facilities after school hours, they are using the community parks more often, and the overall attitude towards their personal fitness and well-being has dramatically improved," said a Hettinger High School staff member.

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More Healthy and Environmentally Safe Schools in Ohio Thanks to PHHS Block Grant Funds

Issue:

Environmentally related asthma is a significant problem caused by indoor pollutants and is a particular problem for school-aged children.

- Asthma is a leading cause of school absenteeism due to chronic illness, resulting annually in approximately 14 million missed school days and an estimated \$957 million lost from caretakers' time off from work.
- Asthma is the third-ranking cause of hospitalization among those younger than 15 years of age.
- It is the most common long-term childhood disease, affecting 6.3 million children. Nearly one in 13 school-aged children has asthma, and approximately 4.2 million children had an asthma attack in the past year.
- A General Accounting Office report to Congress showed that 83% of the 3,600 school buildings in Ohio had at least one unsatisfactory environmental factor.
- 48% of the school buildings reported problems with heating, ventilation, or air conditioning, an area responsible for more than 50% of environmental health problems related to indoor air quality.

Intervention:

The Ohio Department of Health used PHHS Block Grant funds to develop policies to ensure that schools are thoroughly inspected for air quality and potential safety hazards. The School Environmental Health Program

- Worked with Ohio legislators to get Ohio House Bill 203 enacted, which mandates the expansion of school inspections to include safety inspections.
- Established an inspection protocol to be used by 10 pilot local health departments throughout Ohio.
- Provided training and technical support to the local health departments to assist with implementation of school inspections.



Nearly 300 schools were inspected during a pilot test of the new inspection protocol. These inspections assure that schools are following their School Environmental Management Plans, which help them to identify problem areas, prioritize necessary building upgrades, and communicate information about problems to staff, parents, and the community.

Impact:

- 300 schools have been inspected by local health departments and are making necessary environmental changes to their schools.
- 134 local health departments will use the protocol to inspect over 4,000 schools, reaching nearly 2 million students.
- Long-term expectations include a decreased risk of environmental and safety related health problems and injuries in students and staff. These, in turn, should reduce increases in both private and public health care costs.
- Decreased absenteeism in schools from asthma and other environmentally related health conditions will also save money and increase productivity.

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How PHHS Block Grant Dollars Help the Elderly in Pennsylvania Keep Their Independence

Issue:

Living life to the fullest does not stop when you grow older but it can for those who suffer from a fall.

- According to the Pennsylvania Department of Aging, there are more than 2.4 million adults over age 60 in Pennsylvania, a number that is expected to grow to 3 million by 2020.
- Pennsylvania ranks third among states in the percentage of adults over age 65, behind only Florida and West Virginia.
- Nationally, according to the Temple University Institute on Aging, about 50 percent of older persons who are hospitalized due to a fall do not return to independent living; they often require long-term care or nursing home admission.
- In 2003, Pennsylvanians age 65 and older accounted for 79% of the deaths and 72% of hospitalizations related to falls.
- In 2001, government funds paid for 58.8% of hospitalization costs for fall-related injuries in Pennsylvania, totaling \$591 million; including Medicare funds (47.3%) in the amount of \$485 million.
- Medical costs from these injuries and fatalities were more than \$1.2 billion in 2001.



Intervention:

Thanks to PHHS Block Grant funding, the Pennsylvania Department of Health was able to partner with the Temple University Institute on Aging to provide training on how to prevent or reduce falls in the older population. Dr. Roberta Newton, Temple University, developed a HEROS (Health Education Research and Outreach for Seniors) training manual and conducted a train-the-trainer program in Harrisburg, PA. The 15 trainees included the Department's District Injury Prevention Coordinators and County/Municipal Health Department Injury Prevention Staff. Training included

- Teaching how to increase awareness about falls and fall prevention to seniors.
- Assisting professionals with knowledge and skills to provide quick fall screen risk assessment to older individuals.
- Offering information to educate older persons about falls, fall risk, and ways to reduce falls.
- Providing information on intervention programs and materials to develop falls prevention educational programs.

Impact:

The Department of Health will continue to promote fall prevention programs given the need of our older Pennsylvanians.

- During 2004–2005, the six District Health Offices and the 11 County and Municipal Health Departments reached 6,621 residents aged 55 years and older with home safety and falls prevention programs.
- New partnerships continue to form based on HEROS. The City of Chester Health Department has now adopted the HEROS program for their fall prevention effort in the community.

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Fact Sheets Empower Rhode Island Health Practitioners to Eliminate Racial and Ethnic Health Disparities

Issue:

As Rhode Island's population changes, so must its public health care system to keep up with these changes.

The population of Rhode Island is becoming increasingly diverse.

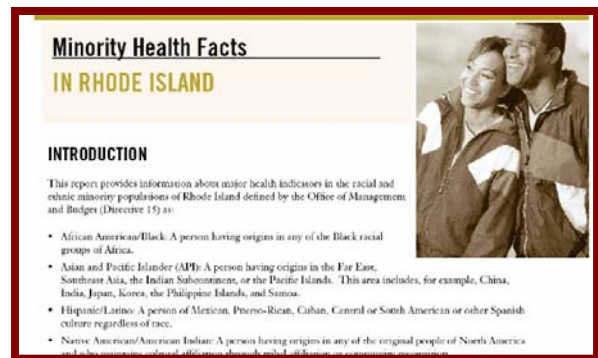
- From 1990 to 2000, Rhode Island's minority population increased by 77%, while the white (non-Hispanic) population decreased by 3%.
- 18% of the state population is a racial or ethnic minority. In general, the median age of Rhode Island's minority population is lower than the median age for the overall state population (36.7 years), and a larger percentage of the minority population is over the age of 50 compared to the overall state population (70%).

Unfortunately, information about the health needs of these growing populations has not been made available. As a result, health practitioners are not reaching these groups because they lack culturally appropriate health information.

Intervention:

To make minority health data more accessible, the Office of Minority Health partnered with the Office of Health Statistics to create minority health fact sheets based on data from the Behavioral Risk Factor Surveillance System (BRFSS). These fact sheets were funded by the Preventive Health and Health Services Block Grant to raise awareness of the health status of minorities and to create programs to better meet their needs.

- Five fact sheets were created for each ethnic population as well and one was created for all populations.
- In December 2004, the fact sheets were printed and disseminated to healthcare providers, partners, and stakeholders.
- A PowerPoint presentation about the fact sheets has been presented at minority health conferences throughout the country.
- Throughout fiscal year 2005, the Rhode Island Department of Health promoted the use of these fact sheets as a resource and for community partners.



The Minority Health Fact Sheets are available at <http://www.health.ri.gov/chic/minority/fact.php>.

Impact:

In 2005, 1,000 sets of Minority Health Fact Sheets were provided to health care practitioners. The fact sheets, now available on The Rhode Island Department of Health's Web site, received an overwhelming positive response. In two months

- 170 African American fact sheets were downloaded.
- 133 Native American fact sheets were downloaded.

It is impossible to eliminate health disparities without accurately and effectively targeting the audience through culturally and linguistic appropriate messages. These fact sheets give community organizations and partners the information needed to create more effective programs to reach these populations.

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[CDC External Web Site Disclaimer](#)

Parishioners in Chesterfield County Start Moving Towards Healthy Living

Issue:

When Reverend Johnny McLendon looked out at his congregation at Fisher Hill Community Baptist Church on Sunday mornings, he saw how many parishioners suffered from poor lifestyle choices and obesity. He felt that the health of his parishioners was at risk at this predominantly African-American church in Chesterfield County, South Carolina. A physically fit man aged 40–50 years, Reverend McLendon knew change had to be made at his church and in his community:

- 30% of the population in the county is completely sedentary, higher than the state rate of 23%,
- 48% report being overweight, with African-Americans more likely to be overweight than their white counterparts,
- African-American men in South Carolina are 90% more likely to die of stroke than white men; African-American women are twice as likely to have a stroke as white women.

Chesterfield County, South Carolina, has more than 150 churches. The heart and soul of the communities within the county are their churches. For Chesterfield County citizens, church is a place where transportation is not a limitation, where attendance is consistent, and where social support is given and received. Therefore, church is the perfect place to educate residents about their health and the local resources available to them.

Intervention:

In 2005, Fisher Hill Community Baptist Church participated in the "Search Your Heart" program. This faith-based program, created by the American Heart Association, aims to increase heart health and prevent strokes in communities of color. Through "Search Your Heart," Fisher Hill Community Baptist Church has

- Begun offering regular aerobics classes (twice per week) in its fellowship hall.
- Created a quarter-mile walking trail around the perimeter of the church and fellowship hall.
- Incorporated healthy meals into church gatherings and
- Offered monthly educational sessions to church members about stress, stroke prevention, and the health effects of nutrition and physical activity.



Preventive Health-Health Services Block Grant and South Carolina Cardiovascular Health Program Grant funded:

- A portion of the South Carolina Department of Health and Environmental Control, Region 4 staff's time to work with the church, and
- Participation costs for the "Search Your Heart" program, which were minimal.

"I am so happy to see the congregation getting excited about living healthier lifestyles. I remind them often how the body is God's temple and that it must be respected and treated well. Attendance at educational sessions and aerobics classes continues to increase, and I can see an improvement in the spirit of our church," said Reverend McLendon.

Impact:

As a result of its participation in "Search Your Heart," Fisher Hill Community Baptist Church has

- Formed a church health committee to implement programs based on the health needs of the church family.
- Challenged other churches in the area to address health and lifestyle behaviors.
- Screened 20% of its adult church members for cardiovascular disease and its risk factors.

Fisher Hill Community Baptist Church received the 2005 Milton Dennis Community Health Award for excellence in community health education programs at the second annual Chesterfield County Interfaith Health Conference. The church plans to make its health programs available to the greater Chesterfield County community soon.

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PHHS Block Grant Launches South Dakota's Healthysd.gov

Issue:

South Dakotans need two things to live their lives: information and inspiration.

- Like the nearly two-thirds (61.8%) of South Dakota adults who were overweight or obese in 2004, Laura and Derek of Pierre, South Dakota knew they needed to change their lifestyles.
- And, like 81% of South Dakota adults in 2003, Laura and Derek didn't get the recommended five servings of fruits and vegetables each day.
- And, like 45% of South Dakota adults in 2003, Laura and Derek did not exercise on a regular basis.

To improve life for people like Laura and Derek, communities and businesses in South Dakota asked the state to develop a Web site to give South Dakotans the tools and resources to lead healthier lives.

Intervention:

In January 2005, with the support of Preventive Health and Health Services (PHHS) Block Grant funds, the South Dakota Department of Health launched www.HealthySD.gov to inform and inspire South Dakotans. The Web site is updated frequently to encourage people to visit the Web site on a regular basis. Individuals of all ages are guided to linked resources for worksites, schools and communities and keep it dynamic. As a result

- A worksite wellness program motivated Laura and Derek to start exercising and eat more fruits and vegetables.
- The "Healthy Hunter" campaign, a creative collaboration between the state health and game, fish and parks departments, targeted the 50,000 licensed South Dakota hunters. Free Global Positioning System (GPS) units were given as prizes to five hunters who registered at www.HealthySD.gov after receiving a promotional mailing.
- The "Governor's Healthy Challenge" motivated South Dakotans to compete as individuals or teams for one month last fall. To generate more participation, the Department of Health distributed free pedometers to the first 1,000 registrants.
- Individuals completing the "5 A Day Challenge" in March 2006 were eligible to receive baskets of produce donated by South Dakota grocery stores.



Impact:

Participants are being inspired to exercise, eat healthier, and take steps toward a healthier lifestyle.

- So far, Laura has lost 40 pounds and Derek has lost 15 pounds.
- www.HealthySD.gov averages approximately 20,000 hits per month as of April 2006.
- More than 1,000 hunters registered during the "Healthy Hunter" promotion.
- 110 teams and 529 individuals competed in the "Governor's Healthy Challenge," and walked enough steps (155,704,977, which equals 66,350 miles) to circle the earth 2½ times during the four-week competition.
- 128 teams and 673 individuals competed in the "5 A Day Challenge," enjoying nearly 6,000 gallons of fruits and vegetables during the 4-week competition.

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Fewer Texans Living in Third World Conditions Thanks to PHHS Block Grant Funds

Issue:

Does the lack of potable water and basic sanitation infrastructure occur only in third world countries? No! Water pollution is at the heart of public health problems facing the U.S.-Mexico border region. Here's why:

- The Rio Grande River is the primary source of drinking water for more than 13 million residents along the Texas-Mexico border.
- Untreated sewage is discharged into this critical water source.
- Basic environmental infrastructure—sewers, garbage disposal, solid waste systems—do not exist in many communities.

In 2005, the Botello Colonia community was typical of Texas border towns without running water. (Colonias are unincorporated communities where people live at or below the poverty level without basic systems like roads or sewers.) This colonia collected rain water in barrels or carried water from the Rio Grande for use in their homes.

As a result, residents were at higher risk for such infectious diseases as viral hepatitis, cholera, typhoid fever and a range of stomach and intestinal diseases.

Intervention:

For the past 10 years, the Office of Border Health, funded in large part by the Public Health and Health Services Block Grant, has initiated partnerships in border colonias to add water and/or sewer services by creating self-help water/wastewater projects.

Essentially, the Office of Border Health has empowered residents to solve their community problems. Based upon the Small Towns Environment Program (STEP) residents are provided with training and technical assistance so they can implement improvements where they are needed most. The STEP model certifies that each community project researches and uses available local resources, provides local project leadership, uses more volunteers than paid professionals, and achieves a minimum 40% cost savings to make water and sewer service affordable for all residents.



Residents with technical expertise create a plan detailing materials, labor and equipment needed to bring water/wastewater into each home in the colonia.

Impact:

Thanks to Block Grant funding, the following has been accomplished:

- In 2005, 3 STEP projects were completed through the mobilization of partnerships.
- These 3 STEP projects served approximately 122 colonias residents in 12 households and realized a 50% total project cost savings.
- Running water was brought into homes at a self-help cost of \$12,000 versus the retail estimate for this project of \$60,000, a savings of 73%.
- Residents now regularly build infrastructure faster and cheaper than paid contracting firms.
- Communities have been strengthened through new relationships and residents have learned new skills.
- Grant funding, public/private partnerships and substantial volunteer work by technical assistants and residents have helped colonias realize their dream of running water and a wastewater system.

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Tipping the Scales toward Healthier Children in Utah

Issue:

Far too many children in Utah are at unhealthy weights. **One of four Utah's school aged children are overweight or at risk for being overweight.** In addition to the health consequences of obesity during childhood and later as adults, obesity is a costly condition. CDC recently estimated Utah's annual direct per capita medical costs for obesity were \$296.37 per adult aged 18 years and older.

Many experts believe that lack of opportunity at school for physical activity and nutrition is contributing to the epidemic of obesity among children. And, it is well established that children who are overweight are significantly more likely to be obese as adults. Creating a healthy, supportive school environment for students is a real challenge for educators when they are under pressure to focus on improving test scores and operate within tight budgets.

Intervention:

The Utah Department of Health and its partners, by combining federal, state, and private funding sources, started the **Gold Medal Schools Program** in 2002 to provide students in Utah's elementary schools with more opportunities to

- Eat healthy
- Be active
- Stay tobacco free



Health experts, teachers, parents and principals developed a broad menu of criteria for Bronze, Silver, Gold and Platinum Award levels. Schools, with support from a coordinator within the school and a mentor from the local health department, create a healthy school environment through policy changes and environmental supports. As schools advance from Bronze to Platinum level, they make sustainable changes that support and enhance healthy behaviors for students and faculty, such as the following:

- Set a policy for at least 90 minutes of structured physical activity for each student per week;
- Create staff and faculty wellness programs; and
- Involve parents through school wellness councils and newsletters and other resources that inform and educate parents.

Impact:

During school years 2002–2005:

- 203 schools have participated in the Gold Medal School program.
- Students from Gold Medal Schools have walked 5 million miles since 2001. That is nearly 11 trips to the moon and back.
- The number of schools with a policy for 90 minutes of physical activity each week for each child has increased from 13.2% to 100.0%.
- Approximately 92,460 children learned about the program.
- Over 80% of Utah school districts are participating.
- New policies and environmental supports (about 10 per school) have resulted in increased physical activity, increased participation in school lunch and decreased plate waste, decreased playground violence, and improved attentiveness in the classroom.
- The cost for the program averages \$5.11 per child annually.

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Taking Charge—Vermont's Blueprint for Health Self Management Program

Issue:

Do you know someone who is overweight, has diabetes, heart disease, lung disease, or arthritis? We all do, and some of these folks are very dear to us. The previously mentioned conditions or diseases are chronic conditions. Depression, high blood pressure, and emphysema are also chronic conditions.

- 51% of Vermonters over 18 years of age are living with ongoing chronic conditions.
- 88% of Vermonters over age 65 have at least two chronic conditions.

Studies show that, on average, people with chronic conditions get the regular care they need only about half of the time and not enough take the personal action needed to achieve the best outcomes. Treating these illnesses consumes more than three quarters of the state's health care budget, and these costs are projected to skyrocket with the aging of baby boomers.

Intervention:

Vermont decided that it had to create fundamental change in the state's health system at every level to address this issue and has implemented *Blueprint for Health*. This approach encompasses everything from patient self-management to provider practice to health system design. The Preventive Health and Health Services Block Grant funded staff support to implement the Healthier Living Workshop program, developed by Stanford University and adopted by Vermont's Blueprint for Health.



Two Vermont communities, Bennington and St. Johnsbury, were chosen to pilot the Healthier Living Workshop in 2005. After being trained in a 4-day, intensive program by Stanford-certified master trainers, lay leaders with chronic conditions facilitated the workshops. Workshop leaders are typically not health care providers, since Stanford found that workshop participants identified with and felt more comfortable with lay leaders. Some of the topics covered in the free 6-week, 2 ½-hour workshops Healthy Living Workshops include

- Techniques to deal with problems such as frustration, fatigue, pain, and isolation.
- Breathing techniques and guided imagery to reduce stress.
- Exercise for improving and maintaining strength, flexibility, and endurance.
- Appropriate use of medications.
- How to better communicate with family, friends, and health professionals.
- Healthy eating habits.
- How to evaluate new health treatments.

Impact:

Vermont is on its way to making a blueprint for healthy living in the state. Vermont has a statewide coordinator for the HealthierLiving Workshop program and nine regional coordinators throughout the state. Three master trainers were trained at Stanford initially, and four more master trainers completed the Stanford program in April 2006. Sixty workshop leaders have been trained by the master trainers. By the end of the 2006, we anticipate that

- 100 leaders will be trained to lead workshops.
- 20 six-week workshops will have been completed and
- 200 participants will attend 4 or more sessions of the 6-week workshops.

The program is new, so overall program effectiveness was not yet been evaluated. However, participants report greater confidence in managing their symptoms, increased activity/energy, weight loss, better breathing, and less stress. Healthier Living Workshop plans to expand statewide in the next year.

The Vermont Department of Health is moving forward with the Blueprint for Health, and PHHS Block Funds helped the state pave the way for healthier Vermonters in the future.

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Community Campaigns Promote Booster Seats. Kids Lives are Saved.

Issue:

Autumn Skeen of Walla Walla, Washington, never pulled out of her driveway until her 4-year-old son Anton was safely buckled into the back seat. That's why Anton's 1996 death in an automobile crash came especially hard for Autumn when she learned that for children below 60 pounds, seat belts aren't enough. "If I knew then that a booster seat would save his life he would be entering high school this year," says Autumn, who joined forces with Washington's *Safe Kids Coalition* to crusade for better protection.

The year he died, Anton was one of 593 people in Washington State who died in car crashes. Nationally and in Washington State, motor vehicle collisions are the single largest killer for children age 4–8 years.

- In 2000, over 1,189 children aged 14 and younger died in motor vehicle crashes.
- In 2001, nearly 300, 000 children aged 14 and younger were injured in vehicle crashes.

In 2000, only 19 percent of Washington's children who should be restrained in booster seats used them. Parents say cost is a factor, putting low-income children at higher risk when their families can't afford the booster seats that could mean the difference between life and death.

Intervention:

The PHHS block grant helped launch Washington's *Safe Kids Coalition* in 1999. Autumn Skeen put a human face on the failure to prevent injuries. Holding a picture of Anton and describing how his life could have been saved, Autumn galvanized the collective power of state and community leaders, who joined with her in 2000 to convince the state legislature to pass "Anton's Law," requiring the use of booster seats by children aged 6-years and younger or weighing less than 60 pounds.



The PHHS block grant continues to support *Safe Kids* and efforts to educate parents about the law. For example:

- Seattle's Central District neighborhood recently identified child passenger safety as a priority. Children aged 4–8 years in the Central District were found to be at higher risk of hospitalization from car-related injuries than children in other areas of Seattle and King County. At the time, there were no commercial outlets in the Central District selling booster seats. The community developed a neighborhood-based program to support and increase the use of booster seats. With support from the PHHS block grant, 56 car seats and booster seats were purchased and distributed through the *Injury Free Seattle* neighborhood clinic. Families in need were identified by community organizations and seats were distributed by trained technicians.

With PHHS block grant support, the Department of Health has purchased and distributed over 525 child safety seats through local child passenger safety teams and local *Safe Kids* coalitions. The child safety and booster seats were distributed to low-income families and installed by trained car seat technicians. Technicians also provided one-on-one instruction on correct use at the time of installation.

Impact:

- A July 2000 baseline assessment found that 19 percent of children weighing between 40 and 80 pounds were using a booster seat. In a 2002 follow-up survey, that number jumped to 47 percent.
- Similar gains were reported in King County, where a 2-year multifaceted community education campaign to increase booster seat use resulted in a 12 percent increase (13 percent in 1999 compared to 25 percent after the community-wide campaign).

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STORIES FROM GRANTEES**
